AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cresemba® (isavuconazonium sulfate) capsules **(Pharmacy)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dosage in Adult Patients:

Dosage Form	Loading Dose	Maintenance Dose*	Quantity Limit
186 mg capsules	Two 186 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Two 186 mg capsules (372 mg) orally once daily	2 capsules per day
74.5 mg capsules	Five 74.5 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Five 74.5 mg capsules (372 mg) orally once daily	5 capsules per day

*Start maintenance doses 12 to 24 hours after the last loading dose

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Recommended Dosage in Pediatric Patients:

Dosage Form	Age	Body Weight (kg)	Loading Dose	Maintenance Dose*	Maximum Quantity Limit
74.5 mg capsules	6 to < 18 years of age	16 kg to < 18 kg	Two capsules (149 mg) orally every 8 hours for 6 doses (48 hours)	Two capsules (149 mg) orally once daily	5 capsules per day
		18 kg to < 25 kg	Three capsules (223.5 mg) orally every 8 hours for 6 doses (48 hours)	Three capsules (223.5 mg) orally once daily	
		25 kg to < 32 kg	Four capsules (298 mg) orally every 8 hours for 6 doses (48 hours)	Four capsules (298 mg) orally once daily	
		≥ 32 kg	Five 74.5 mg capsules (372 mg) orally every 8 hours for 6 doses (48 hours)	Five 74.5 mg capsules (372 mg) orally once daily	

*Start maintenance doses 12 to 24 hours after the last loading dose

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 weeks

- ❑ Member is 6 years of age or older and weighs 16 kg or greater
- ❑ Member must meet **ONE** of the following:
  - ❑ Member has a diagnosis of invasive aspergillosis, and the member has a documented trial and failure, or contraindication, to voriconazole therapy as first line therapy
  - ❑ Member has a diagnosis of invasive mucormycosis
  - ❑ Member is completing a course of therapy that has been initiated in the hospital

    Please provider date therapy was initiated (loading dose included) and how many days completed:

    DATE: _____ DAYS OF THERAPY COMPLETED: _____
- ❑ Provider confirms the member is **NOT** on concurrent use of strong CYP3A4 inducers such as rifampin, carbamazepine, or St. John's Wort

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- ❑ Provider confirms the member is **NOT** on concurrent use of strong CYP3A4 inhibitors such as ketoconazole or high dose ritonavir
- ❑ Provider confirms the member does **NOT** have medical history of familial short QT syndrome

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Member will require secondary prophylaxis to prevent disease recurrence of invasive aspergillosis or mucormycosis
- ❑ Liver function tests are being monitored, and the member is **NOT** experiencing clinical signs and symptoms of liver disease or hepatic failure

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.*